a penalty period must be calculated. The penalty for transfers of assets for less than fair market value in a MAP category of eligibility for institutional care is restricted coverage. "Restricted coverage" means that the applicant or recipient is eligible for all MAD services except services furnished in a nursing facility or services considered to be long-term care services.

(a) Determine the current average monthly cost of nursing facilities for private patients. See [~~Section~~] 8.281.500.13 NMAC.

(b) Divide the total uncompensated value (amount) of the resources transferred for less than fair market value by the current average monthly cost of nursing facilities for private patients.

(c) The result is the number of months and partial months for which the applicant or recipient will be on restricted coverage.

(4) Calculating restricted coverage when the transferred asset is income: If income has been transferred as a lump sum, the period of restricted coverage is calculated based on the lump sum value. For transfers of the right to an income stream, the period of restricted coverage is calculated using the actuarial value of all payments transferred. See [~~Section~~] 8.200.520 NMAC.

C. Transfer rules based on date of transfer: Two sets of rules govern the calculation of penalty periods if a transfer of assets for less than fair market value has occurred. The date of transfer and approval date for the MAP category of institutional care medicaid applicant or recipient institutional care governs which set of rules is used to calculate the penalty period.

(1) For transfers made on or after August 11, 1993: Periods of restricted coverage are calculated as follows (Omnibus Budget Reconciliation Act of 1993):

(a) the period of restricted coverage begins the month the resources were transferred; the total uncompensated value of the transferred assets divided by the average cost to a private patient for nursing facility services in the state at the time of the applicant's or recipient's application is the methodology used to calculate a period of restricted coverage;

(b) transfers for less than fair market value made by an institutionalized SSI applicant or recipient, or a community spouse of institutionalized applicant or recipient may subject the institutionalized applicant or recipient to a period of restricted coverage;

(c) penalty periods are now consecutive rather than concurrent; if multiple transfers occur in different months, the periods of restricted coverage begin with the month of the initial transfer and run consecutively; for example, if an applicant or recipient transfers an asset for less than fair market value in February causing four months of restricted coverage (i.e., February through May) and transfers another asset in April causing three months of restricted coverage, the second period of restricted coverage begins in June and lasts through August; and

(d) if an institutionalized applicant or recipient with a community spouse is placed on restricted coverage as the result of a transfer of assets for less than fair market value and the community spouse subsequently becomes eligible for a MAP category of eligibility for institutional care, any remaining months in the restricted coverage period must be divided equally between the spouses.

(2) For transfers made on or after February 8, 2006: Pursuant to the Deficit Reduction Act of 2005, otherwise eligible institutionalized recipients who transfer assets for less than fair market value after this date are penalized as follows:

(a) the period of restricted coverage begins the first day of the month in which the resources were transferred, or the date on which the individual applicant or recipient meets a MAP category of eligibility, and would otherwise be receiving institutional level of care but for the application of the penalty period, whichever is later, and does not occur during any other period of ineligibility as a result of an asset transfer; see Subsection B of [~~Section~~] 8.281.500.14 NMAC for the methodology used to calculate a period of restricted coverage;

(b) once eligibility has been determined and a penalty period has begun to run, it continues until expiration, whether or not there is a break in the institutionalized recipient's eligibility;

(c) the beginning date of restricted coverage is the first day of the month in which the resources were transferred provided the applicant or recipient is institutionalized and retains [~~his or her~~] their MAP category of eligibility for institutional care; for current recipients who fail to report a transfer, the recipients will continue to receive benefits until the adverse action notice date, but HSD may seek to recover any MAD benefits paid for long-term care services during what should have been a period of restricted coverage; federal law does not provide a basis to impose a transfer penalty based on date of discovery;

(d) for a non-institutionalized applicant or recipient, the date restricted coverage begins is the month in which the applicant or recipient becomes institutionalized;

(e) transfers for less than fair market value made by an institutionalized SSI applicant or recipient, or a community spouse of the institutionalized applicant or recipient may subject the institutionalized applicant or recipient to a period of restricted coverage; and

(f) multiple transfers occurring in different months are added together and calculated as a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

D. Non-excludable transfers: Certain financial instruments must be evaluated before they can be considered a transfer of assets.

(1) Annuities: Annuities belonging to the applicant or recipient or to the spouse of the applicant or recipient must be declared. Annuities must be actuarially sound with no deferral and no balloon payments. Annuities purchased or issued after February 8, 2006, must meet the following additional requirements for exclusion as a transfer of assets:

(a) HSD is named as the remainder beneficiary in the first position for at least the total amount of MAD benefits paid on behalf of the institutionalized applicant or recipient; HSD may be named the remainder beneficiary in the second position if there is a community spouse, or a minor, or a disabled child and is named in the first position if the community spouse or an authorized representative of the child disposes of any such remainder for less than fair market value;

(b) when HSD is a beneficiary of an annuity, issuers of annuities are required to notify MAD of any changes in the disbursement of income or principal from the annuity as well as any changes to HSD's position as remainder beneficiary; and

(c) it is non-assignable and irrevocable.

(2) Life estates: If an applicant or recipient purchases a life estate in another individual's home, the applicant or recipient must live in that home for a period of at least 12 months after the date of purchase or the transaction will be treated as a transfer of assets for less than fair market value.

(3) Promissory notes: If an applicant or recipient uses funds to purchase a promissory note, the repayment terms must be actuarially sound, provide for equal payment amounts with no deferral or balloon payments, and it must contain a provision that prohibits cancellation of the balance upon the death of the applicant or recipient lender. A promissory note not meeting these requirements shall be treated as a transfer of assets for less than fair market value.

E. Excludable transfers: If certain conditions are met, an applicant or recipient is not placed on restricted coverage for transferring assets for less than fair market value.

(1) Transferred asset was home: The asset transferred was a home and title to the home was transferred to:

(a) the spouse of the applicant or recipient;

(b) the son or daughter of the applicant or recipient who is under 21 years of age or who meets the social security administration's definition of disability or blindness; if the child is receiving benefits based on disability or blindness from a program other than social security or SSI, or is not receiving benefits based on disability or blindness from any program, the ISD caseworker must request a determination of disability or blindness from disability determination services;

(c) sibling of the applicant or recipient who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the applicant or recipient was institutionalized; or

(d) son or daughter of the applicant or recipient who was residing in the home for a period of at least two years immediately before the applicant or recipient was institutionalized; for this exclusion to apply, the ISD caseworker must determine that the son or daughter provided care to the applicant or recipient which permitted the applicant or recipient to reside at home rather than in a medical facility or nursing home.

(2) Other asset transfers: Sufficient information must be given to the ISD caseworker to establish that either:

(a) the applicant or recipient intended to dispose of the asset at fair market value; or

(b) at the time of the transfer the applicant or recipient had no expectation of applying for a MAP category of eligibility and the resources were transferred exclusively for a purpose other than to qualify for a MAP category of eligibility as demonstrated by a preponderance of evidence; unless these conditions are met, the transfer is presumed to have been for the purpose of qualifying for a MAP category of eligibility; or

(c) HSD determines that the denial of eligibility would work an undue hardship.

(3) Asset transferred to or for the sole benefit of the community spouse: No transfer penalty is assessed when assets are transferred from one spouse to another (e.g., assets are transferred from an

institutionalized spouse to a community spouse). Any asset transferred to a community spouse or to another individual for the sole benefit of the community spouse in excess of the CSRA is considered to be totally available to the institutionalized spouse and must be spent down before eligibility can be established. No transfer penalty is assessed when assets are transferred to another for the sole benefit of the community spouse if all of the conditions listed in Subparagraphs (a) through (c) below are met.

(a) a transfer is considered to be for the sole benefit of the community spouse if it is arranged in such a way that no individual or entity except the community spouse can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future;

(b) a transfer, or transfer instrument, that provides for funds or property to pass to a beneficiary who is not the community spouse is not considered to be established for the sole benefit of the community spouse; for a transfer to be considered to be for the sole benefit of the community spouse, the instrument or document must provide for the spending of the funds involved for the benefit of the community spouse on a basis that is actuarially sound based on the life expectancy of the community spouse or when the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void;

(c) to determine whether an asset was transferred for the sole benefit of the community spouse, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer; a transfer without such a document cannot be said to have been made for the sole benefit of the community spouse since there is no way to establish, without a document, that only the community spouse will benefit from the transfer.

(4) Asset transfers to or for the sole benefit of a blind or disabled child of the institutionalized individual: No transfer penalty is assessed when assets are transferred to a blind or disabled child of the institutionalized applicant or recipient, or to a trust established solely for the benefit of a blind or disabled child of the institutionalized applicant or recipient. For this exemption to apply, the child must meet the social security administration's definition of blindness or disability. The transfer must either meet the criteria set forth in [~~Section~~] 8.281.500.11 NMAC or meets all of the conditions listed in this section, Subparagraphs (a) through (c) below to be excluded in the eligibility determination process.

(a) A transfer to such a blind or disabled child is considered to be for the sole benefit of that child if the transfer is arranged in such a way that no individual or entity, except the blind or disabled child, can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(b) A transfer, or transfer instrument, that provides for funds or property to pass to a beneficiary who is not the blind or disabled child of the institutionalized applicant or recipient is not considered to be established for the sole benefit of the blind or disabled child. For a transfer or trust to be considered to be for the sole benefit of a blind or disabled child, the instrument or document must provide for the spending of the funds involved for the benefit of the blind or disabled child on a basis that is actuarially sound based on the life expectancy of the child. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

(c) To determine whether an asset was transferred for the sole benefit of the blind or disabled child of the institutionalized applicant or recipient, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the blind or disabled child since there is no way to establish, without a document, that only the blind or disabled child will benefit from the transfer.

(5) Asset transfers to a trust for the sole benefit of a disabled individual under age 65: No transfer penalty is assessed when assets are transferred to a trust established for the sole benefit of an individual under age 65 who meets the social security administration's definition of disability. The transfer must either meet the criteria set forth in [~~Section~~] 8.281.500.11 NMAC or meet all of the conditions listed in Subparagraphs (a) through (c) below to be excluded in the eligibility determination process.

(a) A transfer is considered to be for the sole benefit of a disabled individual under age 65 as described above if the transfer is arranged in such a way that no individual or entity except the disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(b) A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not a disabled individual under age 65 as described above, is not considered to be

established for the sole benefit of the disabled individual. For a transfer or trust to be considered to be for the sole benefit of the disabled individual, the instrument or document must provide for the spending of the funds involved for the benefit of the disabled individual on a basis that is actuarially sound based on the life expectancy of the disabled individual. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

(c) To determine whether an asset was transferred for the sole benefit of the disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the disabled individual since there is no way to establish, without a document, that only the disabled individual will benefit from the transfer.

(6) Assets transfers and qualified state long-term care insurance partnerships (QSLTCIP) protected asset limits (PAL):

(a) No transfer penalty is assessed if at initial determination the applicant or recipient has indicated protection of the transferred asset and there is enough of the PAL to cover the value of the resource at the time of the transfer.

(b) No transfer of assets penalty is assessed if the applicant or recipient has previously indicated an asset for protection and there was enough of the applicant's or recipient's PAL to cover the value of the resource at the time of the transfer.

(c) No transfer penalty is assessed for the portion of a resource which has been partially protected. The unprotected portion of the resource is subject to all assets transfer provisions outlined in [~~this section of this rule~~] 8.281.500.14 NMAC.

F. Re-establishing eligibility: If an asset is transferred for less than fair market value and the applicant or recipient is placed on restricted coverage, [~~he or she has~~] they have options to re-establish [~~his or her~~] their past MAP category of eligibility.

(1) Reimbursement by transferee: The individual to whom the asset was transferred can reimburse the applicant or recipient for the asset at fair market value or liquidate or sell the asset and spend an amount equal to the uncompensated fair market value on the applicant's or recipient's care or other exempt assets as listed in [~~Section~~] 8.281.500.13 NMAC.

(2) Return asset to applicant: The asset can be transferred back to the applicant or recipient, liquated or sold. The applicant or recipient must determine the use of the asset; such use may include spending down the resource limit on the applicant's or recipient's care, classifying the resource as exempt as listed in [~~Section~~] 8.281.500.13 NMAC, or having the asset become a countable resource.

(3) If the transferred asset is restored to an applicant or recipient, [~~he or she~~] they may become totally ineligible for a MAP category of institutional care eligibility due to excess resources. The ISD caseworker must verify that the applicant's or recipient's countable assets do not exceed the standard for a MAP category of institutional care eligibility. If the transferred asset is restored to an applicant or recipient, [~~he or she~~] they may no longer be eligible for a MAP category of institutional care due to the excess resources. The ISD caseworker must verify that the applicant's or recipient's countable assets meet the requirements to have a MAP category of institutional care eligibility.

[8.281.500.14 NMAC - Rp, 8.281.500.14 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.15 RESOURCE STANDARDS FOR MARRIED COUPLES:

A. Community property resource determination methodology: Community property resource determination methodology is used in the eligibility determination for a married applicant or recipient who began institutionalization for a continuous period prior to September 30, 1989.

(1) To determine the countable value of resources, the ISD worker must:

(a) add the total value of all resources owned by both spouses;

(b) exclude the separate property of the non- applicant or recipient spouse; and

(c) attribute one-half of the total value of the community property to the applicant or recipient spouse plus the value of [~~his or her~~] their separate property;

(d) the resulting figure must be less than [~~two thousand dollars ($2,000)~~] $2,000.

(2) Application of community property rules: Under community property rules, all property held by either spouse is presumed to be community property unless successfully rebutted by the applicant or recipient, or representative. To rebut community property status, the applicant or recipient, or representative must document that the property was:

(a) acquired before marriage or after a divorce or legal separation;

(b) designated as separate property by a judgment or decree of any court;

(c) acquired by either spouse as a gift or inheritance; or

(d) designated as separate property by a written agreement between the spouses, including a deed or other written agreement concerning property held by either or both spouses in which the property is designated as separate property.

(i) If one of the parties to this written agreement is incompetent, legal counsel must execute the agreement on behalf of the incompetent spouse.

(ii) Property designated as separate by written agreement is evaluated according to current rules regarding transfer of resources.

(iii) Income cannot be designated as separate by an agreement between spouses; income is considered separate only if it is derived from a resource that has been determined separate.

B. Spousal impoverishment: Spousal impoverishment provisions apply if one spouse of a married couple is institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. See spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA). No comparable treatment of resources and income is required for non-institutionalized applicants or recipients who do not have a spouse remaining in the community. These provisions cease to apply as of the month following the month an applicant or recipient is no longer institutionalized or no longer has a community spouse. If a community spouse or other dependents apply for a MAP category of eligibility they are subject to the rules governing treatment of income and resources for the individual applicant or recipient.

(1) Resource assessment: A resource assessment must be completed to evaluate a couple's resources as of the first moment of the first day of the month one member of the married couple is institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. This process is used to determine the amount of resources which may be protected for the community spouse. See Subparagraph (f) below for resources which must be included in the resource assessment. The resource assessment and computation of spousal shares occurs only once, at the beginning of the first continuous period of institutionalization beginning on or after September 30, 1989. A new resource assessment may be completed if it is later determined that the original resource assessment was inaccurate. Upon the death of the community spouse, the ISD worker may review the applicant's or recipient's resources.

(a) A MAP application does not need to be submitted at the time the assessment is requested. A reasonable fee may be charged for completing assessments which are not made in conjunction with the applications. Applications for assessments are available at the ISD offices which determine eligibility for a MAP category of institutional care. Either member of the couple or their authorized representative may request an assessment application.

(b) The ISD worker must complete a resource assessment using the following criteria:

(i) one member of a married couple became institutionalized on or after September 30, 1989 in an acute care hospital or nursing facility for a continuous period of at least 30 consecutive days;

(ii) the institutionalized applicant or recipient has a spouse who remains in the community in a non-institutionalized setting; and

(iii) the institutionalized spouse remains, or is likely to remain, institutionalized for a period of at least 30 consecutive days based on a written statement from [~~his or her~~] their physician and supporting medical documentation; the institutionalized applicant or recipient is considered "likely to remain" even if [~~he or she does not~~] they do not actually remain in an institution for 30 consecutive days if [~~he or she~~] they met this condition at the beginning of the period of institutionalization.

(c) The ISD worker explains exactly what verification is required to complete the assessment. If the ISD worker requires further information, the individual requesting the assessment is notified in writing and given a reasonable time period of at least 10 working days to provide the additional information.

(d) The institutionalized individual or [~~his or her~~] their spouse or an authorized representative is responsible for providing all verification necessary to complete the assessment.

(e) The ISD worker completes the resource assessment within 45 calendar days of the date of receipt of the completed and signed assessment application unless verification is still pending by the 45th day. In that case, the assessment is not completed until all necessary information is provided by the institutionalized individual or [~~his or her~~] their spouse or authorized representative.

(f) Assessments include the total value of the couple's countable resources held

jointly or separately as of the first moment of the first day of the month one spouse became institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. The assessment form identifies the spousal shares and the CSRA. The couple is entitled to all resource exclusions allowed in [~~Section~~] 8.281.500.13 NMAC except that value limits for the exempt vehicle and household goods of the community spouse do not apply. Assets excluded under the QSLTCIP program are counted in the spousal resource assessment. The disregarded assets are included in determining the amount of the CSRA. The disregarded asset is not counted in determining the applicant's or recipient's eligibility.

(g) When the assessment is complete, the ISD worker copies all documentation used to make the determination of countable resources and retains the documents in the case record. The ISD worker also provides complete copies of the assessment forms to the following parties:

(i) institutionalized applicant or recipient;

(ii) community spouse; and

(iii) authorized representative(s) if any.

(h) When the amount of the couple's total countable resources has been determined, the resulting amount is divided by two to determine the spousal shares. The community spouse is entitled to [~~his or her~~] their spousal share or the MAD minimum resource allowance, whichever is greater, up to the applicable federal maximum standard or an amount determined at a HSD administrative hearing or an amount transferred pursuant to a district court order. The CSRA is the amount by which the greatest of the spousal shares or state minimum resource allowance exceeds the amount of resources otherwise available to the community spouse without regard to such an allowance. The CSRA remains in effect until one of the spouses dies. The remainder of the couple's total countable resources in excess of the CSRA is considered available to the institutionalized spouse. If either the institutionalized spouse or the community spouse is dissatisfied with the computation of the spousal share of the resources, the attribution of resources or the determination of the community spouse resource allowance, [~~he or she~~] they can request a HSD administrative hearing pursuant to [~~Section~~] 8.352.2 NMAC. Refer to [~~Section~~] 8.352.2 NMAC for a detailed description of the HSD administrative hearing process.

(2) CSRA standards: The state minimum resource allowance and the federal maximum standards vary based on when the applicant or recipient became institutionalized for a continuous period of at least 30 consecutive days. See [~~Section~~] 8.281.500.10 NMAC for the applicable standards.

(3) CSRA revision: The CSRA can be revised if either of the following occurs:

(a) a different amount is determined by a HSD administrative hearing final decision or district court decision; or

(b) inaccurate information was provided to the ISD worker at the time the spousal share was calculated.

(4) Resource availability after computation of CSRA: Resources of a couple remaining after the computation of the CSRA are considered available to the institutionalized spouse. These remaining resources are compared to the resource limit.

(a) From the time of the initial determination of eligibility until the first regularly scheduled redetermination, the CSRA is not considered available to the institutionalized spouse.

(b) The CSRA may be applied retroactively for the three months prior to the month of application and is not considered available to the institutionalized spouse until the first periodic review following initial approval.

(5) Resource transfer after computation of the CSRA: When eligibility has been approved for an institutionalized spouse, resources equal to the amount of the CSRA may be transferred to the community spouse. This transfer is intended to assist the community spouse in meeting [~~his or her~~] their needs in the community. Couples should transfer resources in the amount of the CSRA to the community spouse as soon as possible after approval for a MAP category of institutional care eligibility. The institutionalized spouse or authorized representative can complete this transfer at any time between the date of the assessment and the first periodic review 12 months after approval.

(6) Resource transfers which exceed the CSRA: Resources transferred to a community spouse at less than fair market value are not subject to transfer penalties. Resources transferred to the community spouse in excess of the computed CSRA are considered available to the institutionalized spouse and must be spent down to below the resource standard before eligibility can be established. Resources transferred to the community spouse may exceed the CSRA if an increased amount is ordered by any court having jurisdiction or by the MAD director as part of a HSD administrative hearing final decision.

(7) Transfer deadlines: If the resource transfer is not completed by the institutionalized spouse by the end of the initial period of eligibility, the resources are considered completely available to the

institutionalized spouse beginning with the first periodic review after the initial determination of eligibility.

(8) Newly acquired assets: After a continuous period of institutionalization begins, newly acquired resources or increases in the value of resources owned by the institutionalized spouse are countable. Recalculations of eligibility for the institutionalized spouse based on countable resources are effective at the beginning of the month following the month in which new resources were received or an increase occurred in the value of resources already owned.

(a) The institutionalized spouse may transfer newly acquired resources to the community spouse without a penalty up to the difference between the CSRA and the state minimum resource standard in effect as of the date of institutionalization.

(b) After a continuous period begins, new resources acquired by the community spouse or increases in the value of resources which are part of the CSRA are not considered available to the institutionalized spouse.

[8.281.500.15 NMAC - Rp, 8.281.500.16 NMAC, 8/15/2015; A, 3/1/2018; A, 12/1/2022]

8.281.500.16 DEEMING RESOURCES: Deeming of resources applies only during periods when an eligible applicant/recipient under 18 years of age lives at home and during the month the eligible applicant or recipient enters an institution. After the initial month of entry into the institution, only those resources directly attributable to or available to the applicant or recipient are counted and compared to the [~~two thousand dollars ($2,000)~~] $2,000 resource limit.

A. Deeming of resources for children who are blind or have a disability: If an applicant or recipient under 18 years of age who is blind or disabled enters an institution, the resources of the parent(s) are deemed to the applicant or recipient if the parent(s) live in the same household. If an ineligible parent receives temporary assistance to needy families (TANF), resources are not deemed to the applicant or recipient.

B. To determine the amount of resources deemed to the applicant or recipient, the following computation is made:

(1) determine parent(s) resources;

(2) allow parent(s) all the resource exclusions that an eligible applicant or recipient would receive;

(3) the remaining resources in excess of [~~two thousand dollars ($2,000)~~] $2,000 for one parent or [~~three thousand dollars ($3,000)~~] $3,000 for two parents are deemed to the applicant or recipient child; if there is more than one applicant or recipient child, the deemed resources are divided equally; and

(4) the deemed resources are added to whatever countable resources the applicant or recipient child has in [~~his or her~~] their own right; the applicant or recipient child is eligible for a MAP category of institutional care eligibility on the factor of resources if countable resources do not exceed [~~two thousand dollars ($2,000)~~] $2,000.

[8.281.500.16 NMAC - Rp, 8.281.500.17 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.17 INCOME: An applicant's or recipient's gross countable monthly income must be less than the maximum allowable monthly income standard. If an applicant's or recipient's monthly gross countable income is below [~~fifty dollars ($50)~~] $50, the application can still be processed; however, the applicant or the recipient must be referred to the social security administration to apply for SSI. Income may be in the form of cash, checks, and money orders, or in-kind, including personal property or food. If income is not received in the form of cash, the cash value of the item is determined and counted as income. The ISD worker verifies all income and obtains appropriate documentation. Income is counted in the month received. Income is considered available throughout the month regardless of the date received.

A. Types of income: Countable income is the sum of unearned income or earned income, less disregards or exclusions, plus deemed income.

B. Earned income: Earned income consists of the total gross income received by an applicant or recipient for services performed as an employee or as a result of self-employment.

(1) Royalties earned in connection with the publication of an applicant's or recipient's work and any honorarium or fee received for services rendered are considered earned income.

(2) The self-employed applicant or recipient must provide an estimate of [~~his or her~~] their current income based on the tax return filed for the previous year or current records maintained in the regular course of business. The estimate of net earnings for the entire previous taxable year is prorated equally among all months of the current year, even if the business is seasonal.

(a) Consideration is given to the applicant's or recipient's explanation as to why

[~~his or her believes~~] they believe the estimated net earnings for the current year vary substantially from the information shown on [~~his or her~~] their tax return for past years.

(b) A satisfactory explanation is that the business suffered heavy loss or damage from fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic events. Documentation must include copies of newspaper accounts or medical reports and must be filed in the case record to substantiate the need for a reduced estimate of current self-employment income.

C. Unearned income: Unearned income consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self-employment.

D. Deemed income: Deemed income is income considered available to a minor applicant or recipient from [~~his or her~~] their parents.

E. Community property income methodology: If an applicant or recipient is married, community property income methodology shall be used in the eligibility determination, regardless of the living arrangements, if the one spouse has less income than the other spouse or if using the community property methodology would benefit both spouses. Under this methodology, one-half of the community property income is attributed to each spouse. Income is considered separate if it is earned in and is paid from a non-community property state. Proof of separate income is the burden of the applicant or recipient, spouse, or authorized representative.

[8.281.500.17 NMAC - Rp, 8.281.500.18 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.18 INCOME STANDARDS: The applicable income standard used in the determination of a MAP category of institutional care eligibility for an applicant or recipient who has not been institutionalized for a period of 30 consecutive days is the SSI federal benefit rate (FBR) for a non-institutionalized individual. Participation in the medicaid home and community based waiver program is considered institutionalization and counts toward the calculation of the 30-day period. All income, whether in cash or in-kind, shall be considered in the eligibility determination, unless such income is specifically excluded or disregarded.

A. Institutionalization period of 30 consecutive days: After the applicant or recipient has been institutionalized for 30 consecutive days, the application can be approved as of the first day of the 30-day period. Once an applicant or recipient has been institutionalized for 30 consecutive days, the higher income maximum as specified in [~~Section~~] 8.200.520 NMAC is used.

B. Institutionalization period less than 30 consecutive days: If the applicant or recipient leaves the facility before 30 consecutive days, the lower income standard (SSI FBR) is used to establish eligibility.

C. Transfer or death: If an applicant or recipient transfers to another institution or dies prior to completing 30 consecutive days of institutionalization, the higher income maximum is used. See [~~Section~~] 8.200.520 NMAC.

(1) Income exclusions: Income exclusions are applied before income disregards. Exclusions are applied in determining eligibility whether the income belongs to the applicant or recipient or to an individual from whom income is deemed.

(2) Infrequent or irregular income: Exclude the first [~~thirty dollars ($30)~~] $30 per calendar quarter of earned income; and the first [~~sixty dollars ($60)~~] $60 per calendar quarter of unearned income. The following definitions apply:

(a) "Irregular income" is income received on an unscheduled or unpredictable basis.

(b) "Infrequent income" is income received only once during a calendar quarter from a single source and includes:

- **(i)** proceeds of life insurance policies;
- **(ii)** prizes and awards;
- **(iii)** gifts;
- **(iv)** support and alimony;
- **(v)** inheritances;
- **(vi)** interest and royalties; and
- **(vii)** one-time lump sum payments, such as social security.

(c) "Frequency" is evaluated for the calendar quarter (i.e. January - March, April - June, July - September, October - December) but the dollar amount is considered in the month received.

(3) Foster care: Foster care payments are totally excluded if:

(a) the foster child is not eligible for SSI; and

(b) the child was placed in the applicant's or recipient's home by a public or private nonprofit child placement or child care agency.

(4) Domestic volunteer services exclusions: Payments to volunteers under domestic

volunteer services (ACTION) programs are excluded from consideration as income in the eligibility determination process. These programs include the following:

(a) volunteers in service to America (VISTA);

(b) university year for action (UYA);

(c) special demonstration and volunteer programs;

(d) retired senior volunteer program (RSVP);

(e) foster grandparent program; and

(f) senior companion program.

(5) Census bureau employment: Wages paid by the census bureau for temporary employment related to the census bureau are excluded from consideration as income in the eligibility determination process.

[8.281.500.18 NMAC - Rp, 8.281.500.19 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.19 UNEARNED INCOME: Unearned income includes all income not earned in the course of employment or self-employment. If payment is made in the name of either or both spouses and another party, only the applicant's or recipient's proportionate share is considered available to [~~him or her~~] them. If income is derived from property for which ownership is not established, such as unprobated property, one-half of the income is considered available to each member of a married couple.

A. Standards for unearned income: Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement payments or disability benefits, the gross amount is considered countable unearned income.

(1) Social security overpayments: If the social security administration withholds an amount because of an overpayment, the gross social security payment amount is used to determine eligibility. See Subsection B of [~~Section~~] 8.281.500.22 NMAC for instructions regarding calculation of the medical care credit.

(2) Rental income: If an applicant or recipient has rental property, the ISD worker allows the cost of real estate taxes, maintenance and repairs, advertising, mortgage insurance and interest payments on the mortgage as deductions from the amount received as rent.

(3) Interest on promissory note or sales contract: The portion of the payment representing interest received from a promissory note or sales contract is considered unearned income. The market value of promissory notes or sales contracts and the portion of the payment representing payment of the principal are considered resources. See also Subsection L of [~~Section~~] 8.281.500.13 NMAC.

(4) Income from annuities, pensions and other periodic payments: Payments from annuities, pensions, social security benefits, disability, veterans benefits, worker compensation, railroad retirement annuities and unemployment insurance benefits and other periodic payments are counted as unearned income.

B. Unearned income exclusions:

(1) Interest from an excluded burial fund: Interest from an excluded burial fund is not considered unearned income if the interest is applied toward the fund balance. If the interest is paid to the applicant or recipient, it is considered unearned income.

(2) Tax refunds and earned income tax credit: Tax refunds from any public agency for property taxes or taxes on food purchases are totally excluded. Any portion of a federal income tax return which constitutes an earned income tax credit is excluded.

(3) Grants, scholarships and fellowships: All grants, scholarships and fellowships used to pay tuition and fees at an educational institution, including vocational and technical schools, are totally excluded. Any portion of a grant, scholarship or fellowship used to pay any other expenses, such as food, clothing or shelter, is not excluded.

(4) Veteran's pensions: Allowances for aid and attendance (A&A) and unusual medical expenses (UME) are excluded from unearned income for determination of eligibility. If an applicant or recipient receives an augmented VA pension as a veteran or veteran's widow or widower, the pension amount may include an increment for a dependent. If so, the VA must be contacted to provide documentation of the portion of the pension which represents the dependent's increment. When verified, this amount of the VA pension is considered the dependent's income.

(5) Payments by a third party: Third party payments are excluded as income if made directly to the applicant's or recipient's creditor.

(a) Third party payments may include mortgage payments by credit life or credit disability insurance and installment payments by a family member on a burial plot or prepaid burial contract.

(b) Interest from a burial contract that is automatically applied to the outstanding

balance is excluded from unearned income. If the payment or interest is sent to the applicant or recipient, it is counted as unearned income regardless of the sender's (third party's) intentions. This applies even if the sender specifies the purpose of the payment on the check. This provision does not apply if the signature of the creditor and the applicant or recipient must both be present in order to negotiate the check (two-party check).

(6) Indian tribe per capita payments: Funds held in trust by the secretary of the interior for an Indian tribe and distributed on a per capita basis and any interest and investment income from these funds, are excluded as income and resources in the eligibility determination process and the computation of the medical care credit.

(7) Plans for achieving self-support: Income derived from, or necessary to, an approved plan for achieving self-support for a blind or disabled applicant or recipient under 65 years of age is excluded.

(a) For an applicant or recipient who is blind or disabled and over 65 years of age, this exclusion applies only if [~~he or she~~] they received MAD services for the month preceding [~~his or her~~] their 65th birthday.

(b) The self-support plan must be in writing and contain the following:

(i) designated occupational objective;

(ii) specification of any savings (resource) or earnings needed to complete the plan, such as amounts needed for purchase of equipment or for financial independence;

(iii) identification and segregation of any income saved to meet the occupational goal;

(iv) designation of a time period for completing the plan and achieving the occupational goal.

(c) Plans for achieving self-support are developed by vocational rehabilitation counselors. If a self-support plan is not in place, the ISD worker makes a referral to the division of vocational rehabilitation (DVR).

(d) The ISD worker forwards the written plan and documentation to the MAD eligibility unit. The plan must be approved by that unit.

(e) An approved plan is valid for the following specified time periods:

(i) initial period of no more than 18 months;

(ii) extension period of no more than 18 months;

(iii) final period of no more than 12 months; and

(iv) total period of no more than 48 months.

(8) Agent orange settlement payments: Agent orange settlement payments made to applicant or recipient veterans or their survivors are excluded from consideration as income in determining eligibility.

(9) Radiation Exposure Compensation Act payments: Payments made under the Radiation Exposure Compensation Act are excluded from consideration as income in determining eligibility.

(10) Victims compensation payments: Payments made by a state-administered fund established to aid victims of crime are excluded from consideration as income in determining eligibility. These payments are included as countable income when calculating the medical care credit.

(11) Lump sums for retroactive periods: SSI lump sum payments for retroactive periods are excluded from consideration as countable income in the month received.

(12) Life insurance and other burial benefits: Life insurance and other burial benefits are unearned income to the beneficiary (not the owner). The ISD worker must subtract the amount spent on the insured recipient's last illness or burial up to [~~one thousand five hundred dollars ($1500)~~] $1,500. Any excess is counted as unearned income.

(13) One hundred percent state funded assistance payment: Any one hundred percent-state-funded assistance payment based on need, such as general assistance (GA) is excluded. Any interim payments made by a state or municipality from all state or local funds while an SSI application is pending are excluded.

(14) National vaccine injury compensation program (NVICP) payment: The NVICP funds are excluded as income or a resource until they are actually disbursed by the issuing agent. However, they are counted as income in the month in which they are received and counted as a resource in the following months, provided that the funds in question are not specifically earmarked for medical expenses. If the payment is designated for both living expenses and medical care, a determination must be made to identify how much of the payment is for living expenses, and how much is for medical care. The only portion actually counted then is that amount which is for living expenses. Therefore, a determination must be made as to how the payment is apportioned before making an eligibility determination.

(15) Remembrance, responsibility and the future payments: Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded as income in determining eligibility.

[8.281.500.19 NMAC - Rp, 8.281.500.20 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.20 DEEMED INCOME:

A. Availability: Deemed income is income considered available to a minor applicant or recipient from [~~his or her~~] their parents. Deeming of resources and income applies only during periods when an applicant or recipient under 18 years of age is living with [~~his or her~~] their parents and during the month of entry into an institution.

B. Situations in which deeming occurs: Deeming of income occurs:

(1) from ineligible parent to eligible child; or

(2) if there is both a MAP eligible parent and a MAP eligible child in the home.

C. Computing deemed income: The ISD worker computes the total monthly amount of parental unearned and earned income and then computes the deemed income available to the applicant or recipient child. If the deemed income plus the child's separate income exceeds the applicable maximum, the child will not have a MAP category of institutional care eligibility for that month.

(1) Parents and children receiving aid: If one of the applicant or recipient child's parents is receiving any benefit or assistance paid by a governmental agency on the basis of economic need, that benefit plus all the income of that parent is excluded from the deeming process. This exclusion applies only to the income of the parent who receives the benefit. Even if the income of one parent is excluded, that parent is still considered a member of the household for purposes of determining the parental allocation. Provisions for deeming income do not apply to benefits under temporary assistance to needy families (TANF). No income is deemed to a parent or child(ren) if that parent or child(ren) is (are) receiving TANF assistance.

(2) Applicant or recipient parent and [~~his or her~~] their child(ren): If a household is composed of an applicant or recipient parent and an applicant or recipient child(ren), the parent's income is determined according to the methodology appropriate to the MAP category of eligibility which [~~he or she receives~~] they receive.

(a) If there is enough income to make the applicant or recipient parent ineligible, the remainder of the income is carried over to be deemed to the child(ren).

(b) If there is more than one potentially eligible child, the deemed income is divided equally among them. If total countable income is less than the applicable maximum, the applicant or recipient has a MAP category of institutional care eligibility on the factor of income.

(c) If an applicant or recipient is determined to meet the MAP category of institutional care eligibility, the ISD worker must recompute available income for the following month based on separate income to establish the correct medical care credit. See 8.281.500.23 NMAC, *post-eligibility/medical care credit.*

[8.281.500.20 NMAC - Rp, 8.281.500.21 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.21 DISREGARDS: Income disregards are determined on an individual basis. Disregards may be applied to any appropriate month of assistance, regardless of which income maximum is used.

A. [~~Twenty dollar ($20)~~] $20 disregard: The first [~~twenty dollars ($20)~~] $20 of unearned or earned income received in a month is disregarded. This disregard is applied first to unearned income and, if any amount remains, to earned income. If there is no unearned income, the entire [~~twenty dollars ($20)~~] $20 disregard is applied to earned income. This disregard is not applied to any payment made to the applicant or recipient through government assistance programs or private charitable organizations, where payments are based on need. These payments include financial assistance, TANF, assistance from catholic charities, salvation army, bureau of Indian affairs, and VA pension (not compensation) payments.

B. Additional earned income disregard: After applying the [~~twenty dollars ($20)~~] $20 disregard as specified in Subsection A of [~~Section~~] 8.281.500.21 NMAC if appropriate, the first [~~sixty five dollars ($65)~~] $65 of monthly earned income plus one-half of the remainder is also disregarded.

C. Work-related expenses of the blind: Work-related expenses of an employed applicant or recipient or couple who are legally blind are disregarded. The dollar amount of expenses which may be disregarded must be reasonable. Expenses are disregarded when paid and must be verified.

(1) This disregard does not apply to an applicant or recipient who is blind and is 65 years or age or older, unless [~~he or she was~~] they were receiving SSI payments due to blindness in the month before turning

65 or received payments under a state aid to the blind program.

(2) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus/taxi cab fare, or [~~fifteen cents (15 cents)~~] $0.15 per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools and other necessary equipment; and

(h) special expenses necessary to enable an applicant or recipient who is blind to engage in employment, such as a seeing-eye dog or Braille instructions.

D. Student earned income disregard: Up to [~~one thousand two hundred dollars ($1,200)~~] $1,200 per quarter or a maximum of [~~one thousand six hundred twenty dollars ($1,620)~~] $1,620 per calendar year of the earned income of certain students may be disregarded. To qualify for this disregard, the applicant or recipient must meet all of the following requirements:

(1) under 22 years of age;

(2) unmarried;

(3) not head of a household; and

(4) in regular attendance at a college or university, for at least 12 semester hours or vocational or technical training course for at least 20 hours per a calendar week.

(a) This disregard applies only to a student's own earned income and includes all payments made as compensation for services, such as wages from employment or self-employment, or payments from programs such as neighborhood youth corps or work-study.

(b) This disregard is available in addition to any exclusions applied to grants, scholarships or fellowships and in addition to any other allowable disregards.

E. Child support payments: One-third of the amount of child support payments made to a child applying for a MAP category of institutional care eligibility is disregarded. The remainder is considered unearned income, subject to the appropriate disregards outlined below.

[8.281.500.21 NMAC - Rp, 8.281.500.22 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.22 POST ELIGIBILITY/MEDICAL CARE CREDIT: Once financial eligibility for a MAP category of institutional care has been established, the ISD worker must determine the following.

A. Medical care credit: The medical care credit is the amount of the applicant's or recipient's income used to reduce the MAD payment to the institution where [~~he or she~~] they reside. An applicant or recipient must make this payment directly to the institution. Applicants or recipients eligible for a MAP category of institutional care due to institutionalization in an acute care hospital or an in-state in-patient rehabilitation center are not charged a medical care credit. The amount of the medical care credit is always determined prospectively. The ISD worker computes a medical care credit starting with the first full month of institutional care. No medical care credit is required for the month the recipient enters the institution if [~~he or she is~~] they are admitted after the first moment of the first day of the month.

(1) No medical care credit for the month of discharge or death: An applicant or recipient is not required to pay a medical care credit for the month of discharge from the institution. The medical care credit must be paid if the applicant or recipient is transferred to another institution or makes a short visit outside the institution. No medical care credit is charged for the month in which a recipient who received MAD institutional care services dies. This will prevent a deficit for the institution when a benefit, such as social security, must be returned due to the death of a beneficiary.

(2) Application delay: If there is a delay between application and approval, an applicant or recipient incurs a liability for a medical care credit. The ISD worker notifies the applicant or recipient of this liability during the application process and informs [~~him or her~~] them of the amount of the medical care credit [~~he or she~~] they should pay. The applicant or recipient is encouraged to pay the medical care credit to the institution before approval of the application.

(3) Medical care credit during retroactive months: No medical care credits are applied for any period of retroactive eligibility under this provision.

B. Computing the medical care credit: The current personal needs amount (PNA) of an applicant or recipient monthly income is protected for [~~his or her~~] their personal use in a nursing facility. Each year thereafter,

the amount of an applicant's or recipient's monthly income shall be adjusted according to the consumer price index as indicated in [~~Section~~] 8.200.510 NMAC. The excess over the amount protected, subject to other deductions, is applied toward payment for care in the nursing facility as a medical care credit.

(1) See Paragraph (6) of Subsection B of [~~Section~~] 8.281.500.22 NMAC for personal needs allowance for veterans or surviving spouses.

(2) An applicant's or recipient's total income, including amounts disregarded in determining eligibility, is used to compute the medical care credit with the following exceptions:

(a) Indian tribe per capita payments (see Subsection B of [~~Section~~] 8.281.500.19 NMAC);

(b) German reparation payments; and

(c) social security administration overpayments.

(i) When the social security administration withholds an amount due to an overpayment, the social security gross payment amount is used to determine eligibility per Subsection A of [~~Section~~] 8.281.500.19 NMAC. To determine the amount used in calculating the medical care credit, the ISD worker ascertains whether a social security (Title II) overpayment is being recouped or whether an SSI overpayment is being recouped from a social security benefit check (a cross-program recoupment). Cross-program recoupments are at the recipient's option so the gross benefit amount is used to calculate the medical care credit.

(ii) Recoupment of a social security overpayment from a social security benefit check is mandatory. In such cases, the net social security benefit amount is used to calculate the medical care credit.

(d) payments from the Radiation Exposure Compensation Act.

(e) 'remembrance, responsibility and the future' payments.

(3) Dependent children at home: If an institutionalized applicant or recipient with no spouse has dependent children at home who are ineligible for TANF or assistance from any other program, or are eligible for an amount less than the TANF need standard, an allowance for each child of up to the current TANF standard of need may be deducted from the institutionalized applicant's or recipient's income which is in excess of the applicant's or recipient's personal allowance.

(4) [~~**Health insurance premiums and non-covered medical expenses:** An applicant or recipient is allowed a deduction in the medical care credit computation for the full amount of any health insurance premiums paid by the applicant or recipient. A deduction for the full amount of long-term care insurance and qualified state long-term care insurance partnership premiums are also allowed. A deduction of up to the medicare part B premium amount is allowed for medical expenses currently being paid by an applicant or recipient which are not covered by a MAP category of institutional care eligibility. This includes other medical care recognized under state law but not covered by institutional care medicaid. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.~~] **Expenses not subject to third party payment 42 CFR 435.725:** Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including:

(a) medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) necessary medical or remedial care recognized under state law but not covered under the state medicaid plan, subject to reasonable limits on amounts of these expenses. HSD has the following reasonable limits on amounts for necessary medical or remedial care not covered under medicaid:

(i) For expenses not covered under the [~~State~~] state Plan or expenses covered under the state plan, but not paid for by medicaid, the amount of the deduction is the billed amount not to exceed the provider's usual and customary charges except for unpaid nursing facility expenses.

(ii) To be deducted, an expense must be for medically necessary medical or remedial care rendered to the applicant or beneficiary and prescribed by a health care practitioner acting within their scope of practice who meet the qualifications of an eligible medicaid provider as listed in the New Mexico Administrative Code (NMAC) [~~"Professional Providers, Services, and Reimbursement" section found at 8.310.3.9 NMAC,~~] 8.310.3.9 even if such practitioner is not a medicaid provider.

(iii) A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of the current application. For each month of unpaid nursing facility services incurred during this period, deductions are allowed at an amount not to exceed the average monthly private rate of nursing facility services, as used to calculate asset transfer penalties and which is updated annually in 8.200.510.13 NMAC or a prorated amount of this figure, for unpaid nursing facility services that are for less than a full month.

(iv) The deduction for medical and remedial care expenses that were incurred as the result of a transfer penalty period is limited to zero.

(v) Expenses for cosmetic/elective procedures (e.g., face lifts or liposuction etc.) are not allowed as deductions except when prescribed by a health care practitioner.

(vi) Expenses from medical or remedial procedures that were denied coverage by an insurer, including medicaid, on the basis of a lack of medical necessity are not allowed.

(5) Court-ordered support: A deduction for the full amount of court-ordered child or spousal support is also allowed for the applicant or recipient.

(6) Personal needs allowance for recipients in an ICF-IID: If an applicant or recipient who is institutionalized in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) has a monthly income from employment in a sheltered workshop or other work activity program, up to the first [~~one hundred dollars ($100)~~] $100 of this earned income is protected for the applicant's or recipient's personal needs. This amount is in addition to the applicant's or recipient's personal needs allowance protected from income from any source. If the applicant's or recipient's income is from any other source, the personal needs allowance is set at the amount as set forth in [~~Section~~] 8.281.500.12 NMAC.

(7) Veterans administration (VA) benefits: The ISD worker must contact the VA on each veteran's case to verify how much of the benefit is for pension, aid and attendance (A&A) or unusual medical expenses (UME).

(a) For MAP eligible veterans with no spouse or dependent children, and for surviving spouses of veterans without dependent children who do not reside in a state veteran's home (Fort Bayard or Truth or Consequences):

(i) exclude the A&A and UME in the medical care credit computation;

(ii) allow the personal needs allowance as set forth in [~~Section~~] 8.281.500.12 NMAC;

(iii) the benefit for applicant or recipient will be reduced to [~~ninety dollars ($90)~~] $90 per month effective the latest of the following;

(iv) the last day of the calendar month in which medicaid coverage begins;

(v) the last date of the month following 60 calendar days after issuance of a reduction notice;

(vi) the earliest date on which payment may be reduced without creating an overpayment;

(vii) when the benefit is reduced to [~~ninety dollars ($90)~~] $90, recomputed the medical care credit to allow [~~ninety dollars ($90)~~] $90 for personal needs.

(b) For MAP eligible veterans with no spouse or dependent children, and for surviving spouses of veterans without dependent children who do reside in a state veteran's home (Fort Bayard or Truth or Consequences):

(i) include the A&A and UME in the medical care credit computation;

(ii) allow [~~ninety dollars ($90)~~] $90 for [~~his or her~~] their personal needs;

(iii) the benefit for the applicant or recipient is not reduced to [~~ninety dollars ($90)~~] $90.

(c) Benefits for the following applicants or recipients are not reduced to [~~ninety dollars ($90)~~] $90 a month, regardless of whether or not they reside in a state veteran's home:

(i) veterans who have a spouse or dependent child(ren);

(ii) surviving spouses of veterans who have dependent child(ren).

(d) The ISD worker allows these applicants or recipients the allowance as set forth in [~~Section~~] 8.281.500.12 NMAC, for personal needs.

C. Computing medical care credits for married institutionalized applicants or recipients: To calculate the medical care credit for a married institutionalized applicant or recipient, the "name-on-the-check" rule applies. The ISD worker uses only the income belonging to the institutionalized applicant or recipient to compute [~~his or her~~] their medical care credit. Total gross income before any deductions is used in this process.

(1) Treatment of VA aid and attendance (A&A) and unusual medical expenses (UME): Allowances for A&A and UME are considered when computing the medical credit in accordance with Subsection B of [~~Section~~] 8.281.500.22 NMAC.

(2) Court-ordered support: A deduction for the full amount of court-ordered child or spousal support is also allowed for the applicant or recipient.

D. Computing medical care credits for an institutionalized couple: To compute medical care

credits for each of an eligible institutionalized couple, the ISD worker totals the couple's gross income and divides by two. The personal needs allowance as set forth in Subsection B of [~~Section~~] 8.281.500.22 NMAC is subtracted from each amount for each applicant's or recipient's personal needs and added to any allowable amount(s) paid by that applicant or recipient for noncovered medical expenses.

E. Medical care credit deductions: The ISD worker applies the deductions listed below in the following order when determining the medical care credit:

(1) institutionalized spouse's personal needs allowance as set forth in [~~Section~~] 8.281.500.12 NMAC;

(2) community spouse monthly income allowance (CSMIA); the CSMIA deduction is permitted only to the extent that the income is available and is actually contributed to and accepted by the community spouse or other dependent family members:

(a) the CSMIA is calculated by starting with the minimum monthly maintenance needs allowance (MMMNA) and subtracting the community spouse's total gross income;

(b) both spouses shall be given notice of the amount of the CSMIA;

(c) if either spouse is dissatisfied with the amount of the CSMIA, [~~he or she~~] they can request a HSD administrative hearing pursuant to [~~Section~~] 8.352.2 NMAC, to establish that the community spouse needs income above the minimum monthly maintenance needs allowance; the spouse must demonstrate that the community spouse needs the additional income above the level otherwise provided by the minimum monthly maintenance needs allowance due to exceptional circumstances resulting in significant financial duress; if the spouse establishes that the community spouse needs additional income due to exceptional circumstances resulting in significant financial duress, there shall be substituted for the CSMIA such amount as is necessary to alleviate the financial duress and for so long as the exceptional circumstances exist; if as a result of a HSD administrative hearing final decision or district court hearing, additional income is granted to the community spouse for a specified period of time, when that time expires, the original CSMIA, as calculated by the ISD worker is reinstated; the exceptional circumstances can include medical, remedial or other support expenses that jeopardize the ability of the community spouse to remain self-sufficient in the community;

(d) if as a result of a district court hearing or a HSD administrative hearing final decision, a request for a revision of the CSMIA is granted, the revised amount shall be substituted for the CSMIA calculated by the ISD worker; and

(e) when the institutionalized applicant's or recipient's income is insufficient to provide the minimum authorized deduction for the community spouse, either spouse can request a HSD administrative hearing pursuant to [~~Section~~] 8.352.2.NMAC if either spouse establishes that the CSRA (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the MMMNA, there shall be substituted, for the CSRA, an amount adequate to provide the MMMNA;

(3) an excess shelter allowance for allowable expenses of the community spouse which exceed thirty percent of the MMMNA standard up to a specified maximum; the following expenses are allowed for the primary residence of the community spouse:

(a) rent or mortgage payment, including interest or principal;

(b) home taxes and insurance;

(c) maintenance charges for a condominium or cooperative; and

(d) amount equal to the standard utility allowance used by the food stamp program if the community spouse incurs a heating or cooling expense; utility expenses included in the rent or the basic maintenance fee for a condominium or cooperative, are not allowed.

(4) The total CSMIA and excess shelter allowance combined may not exceed the standard amount per month, unless the MAD director or a district court orders the institutionalized spouse to pay an increased amount.

(5) An allowance for each eligible family member equal to one-third of the balance obtained after deducting the family member's gross income from the MMMNA. Family members include the couple's minor child(ren) under the age of 18 years, disabled adult child(ren) of the couple who meet the social security administration's definition of disability and dependent sibling(s) or parent(s) of the couple. These family members must reside with the community spouse. The dependency requirements are met if either member of the couple could claim the family member as a dependent for tax purposes.

(6) The deductions for the community spouse and dependent family members apply only so long as there is a community spouse. Deductions for the community spouse and other family members shall cease in the first full calendar month after the community spouse dies, becomes divorced, or is institutionalized.

(7) Health insurance premiums and non-covered medical expense deduction.

F. Reporting requirements: An applicant or recipient, spouse, or authorized representative is required to report to the ISD worker any change in circumstances which may affect eligibility or the medical care credit amount within 10 working days after the date the change occurs. Changes which cause adjustments in an applicant's or recipient's medical care credit amount are effective the month after the change occurs. Family members receiving allowances must also report all changes of gross income and residence within 10 working days after the date the change occurs. Changes must be reported when the institutionalized spouse stops making all or part of a maintenance allowance available to the community spouse or other family member(s), or when the recipient of a maintenance allowance begins to refuse all or part of the income.

G. Changes in income and recipient medical care credit: Payments received by an applicant or recipient, such as social security, VA, retirement or other benefits, are applied to billing for services for the same month in which the payment is received. If the income increases, the institution must continue to collect the amount indicated on the medical care credit report in the eligible recipient's file and immediately advise the ISD worker of the change. The ISD worker processes the change, notifies the institution and the eligible recipient of the new medical care credit amount and indicates the month in which the higher amount is to be collected. The difference between the medical care credit amounts is deposited in the eligible recipient's personal fund account until the change is effective.

[8.281.500.22 NMAC - Rp, 8.281.500.23 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.23 UNDUE HARDSHIP: An applicant or recipient subject to a penalty for transfer of assets for less than fair market value may apply for a waiver of the regulation regarding transfer of assets as constituting an undue hardship. The facility where an institutionalized applicant or recipient resides may file an application for waiver of the requirement on behalf of the applicant or recipient with the applicant's or recipient's or authorized representative's consent.

A. The transfer must have been made to someone other than a family member. "Family member" includes son, daughter, grandson, granddaughter, step-son, step-daughter, in-laws, mother, father, step-mother, step-father, half-brother, half-sister, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, step-sister, step-brother.

B. The applicant or recipient must demonstrate that the application of the transfer of assets regulation would deprive the applicant or recipient of:

(1) medical care such that the applicant's or recipient's health or life would be endangered; or

(2) food, clothing, shelter or other necessities of life.

C. The applicant or recipient or the facility where the applicant or recipient resides must submit any documentation to support the claim that application of the transfer of assets requirement would constitute an undue hardship within 30 calendar days of the date of the notice regarding the penalty to the ISD county office.

D. Undue hardship does not exist when the application of a transfer penalty causes an applicant or recipient or [~~his or her~~] their family members inconvenience or restricts their lifestyle.

E. The county director of the ISD office will make a decision regarding an application for waiver of the transfer of assets requirements within 30 calendar days of receipt of the application.

(1) Notice of the decision shall be mailed to the applicant or recipient or [~~his or her~~] their authorized representative.

(2) MAD may make payments to the nursing facility for an applicant or recipient who is a resident of the facility while an application for waiver of the requirement is pending to hold the bed for the applicant or recipient. HSD may make payments for no more than 30 calendar days.

F. If the applicant's or recipient's application for waiver of the transfer of assets requirement is granted, MAD shall pay for long-term care services prospective from the date of the application. MAD shall pay for long-term care services as long as the circumstances constituting the basis for waiver of the application of the requirement exist. If the applicant's or recipient's application for waiver of the transfer of assets requirement is denied, the applicant or recipient can request a HSD administrative hearing pursuant to [~~Section~~] 8.352.2 NMAC within 90 calendar days of the date of the notice of denial.

G. The applicant or recipient or [~~his or her~~] their authorized representative must notify the ISD worker of any change in circumstances which affects the application of the undue hardship waiver exception within 10 working days of the change in circumstances. MAD will review the change of circumstances and determine the next appropriate action, which may include withdrawal of the waiver.

[8.281.500.23 NMAC - Rp, 8.281.500.24 NMAC, 8/15/2015; A, 12/1/2022]